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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/17/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lorcet 10/650 mg #120 and Ambien 10 mg #30

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Anesthesiology; Board Certified Pain Management

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. The reviewer finds the requested Lorcet 10/650 mg #120 and Ambien 10 mg #30 cannot be supported as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Request for IRO 06/20/12
Utilization review determination 05/15/12
Utilization review determination 06/13/12
Medical records Dr. 01/12/12, 01/30/12, and 06/05/12
Prescription 05/08/12

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male who is reported to have sustained work related injuries on xx/xx/xx. On 01/12/12 the claimant was seen by Dr.. He is reported to be status post bilateral transforaminal epidural steroid injection for pain that radiates into his lower extremities. He reported his back pain is mainly located over low back without radiation. He apparently had 60% relief with previous procedure. He denies any side effects from current medications, which provided him good relief. His current medications include Robaxin 750 mg, Lorcet 10/650 mg, Motrin 600 mg, Lyrica 75 mg and Flexeril tablet 10 mg. Past surgical history includes lumbar fusion. On physical examination he is hypertensive with blood pressure of 123/100. He is tachycardia with heart rate of 113. Pain is 8/10. He is tender over the midline of upper and lower lumbosacral spines. He has tenderness over the lumbosacral spine muscles and tenderness over the facets. He is tender over sacroiliac joints. Faber's, Gaenslen's and Yeoman's are positive bilaterally. Straight leg raise is positive bilaterally. Deep tendon reflexes are decreased at patella and increased at Achilles tendon on right and absent on left. He is diagnosed with failed back surgery syndrome. Additional nerve root blocks have been recommended.

The claimant was seen on 06/05/12. It is noted that his low back pain is graded 4/10 with intermittent radiation to lower extremities. He described some numbness and tingling in his

feet. His low back pain was exacerbated with prolonged sitting or standing. It is reported his oral medications were not approved and he has been complaining of severe pain over the past weeks. He reported being unable to perform home exercises. It is again noted back pain is 4/10. The claimant complains of poor sleep because high pain levels. Physical examination is unchanged. Physical examination is unchanged.

The initial request was reviewed on 05/14/12. The reviewer non-certified the request noting that the claimant has a diagnosis of a failed back surgery syndrome. The claimant is chronically maintained on Lorcet 10 650 as well as other medications. He notes that there is no current data regarding the claimant's reported sleep disturbance or documentation such as an Epworth sleep scale. He opines in the absence of more detailed clinical information the medical necessity was not established.

The subsequent appeal request was reviewed on 06/13/12. The reviewer notes that the appeal for Lorcet 10 650 and Ambien 10mg is non-certified. He notes that the claimant has a history of low back pain and posterior lateral lumbar fusion in 2004. He notes that the claimant's current pain complaints are not rated on a VAS and there is not a good description regarding the symptoms of possible insomnia to warrant the proposed medications. He subsequently upholds the previous denial and non-certifies the request.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The submitted clinical records indicate that the claimant has a failed back surgery syndrome for which he receives chronic treatment. Treatment has included oral medications in conjunction with interventional procedures. It was noted that on 01/12/12 the claimant was reported to be 60% improved from previous injections and was recommended to undergo additional injections. Most recent clinic note dated 06/05/12 indicates that the claimant has chronic low back pain and has not been authorized medications, yet at this visit the claimant's pain level was reported to be 4/10. The claimant is reported to have poor sleep because of high pain levels, yet in the absence of medications over a period of time the claimant's pain level is only 4/10. The record does not provide any data to establish that the provision of opiate medications results in significant functional improvement. Additionally, there is no substantive data adequately documenting the claimant's insomnia to establish the medical necessity for the chronic use of Ambien. Based upon the submitted clinical data, the reviewer finds the requested Lorcet 10/650 mg #120 and Ambien 10 mg #30 cannot be supported as medically necessary per the Official Disability Guidelines.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
[ ] INTERQUAL CRITERIA
[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
[ ] MILLIMAN CARE GUIDELINES
[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
[ ] TEXAS TACADA GUIDELINES
[ ] TMF SCREENING CRITERIA MANUAL
[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)